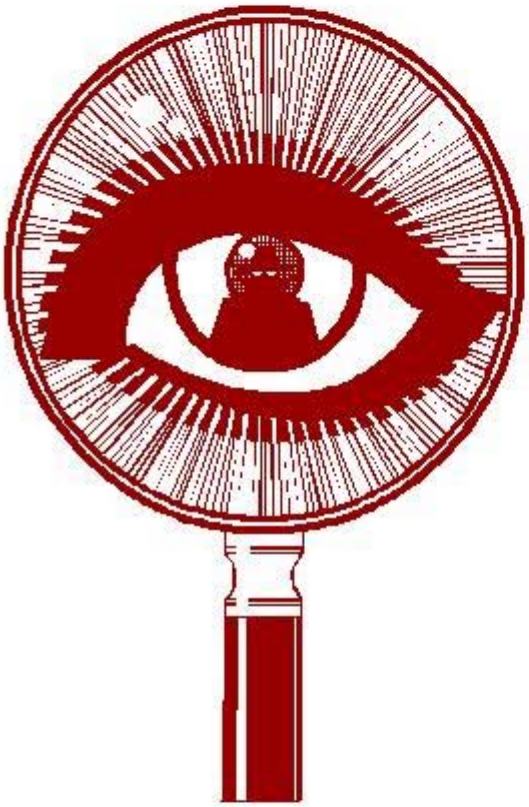
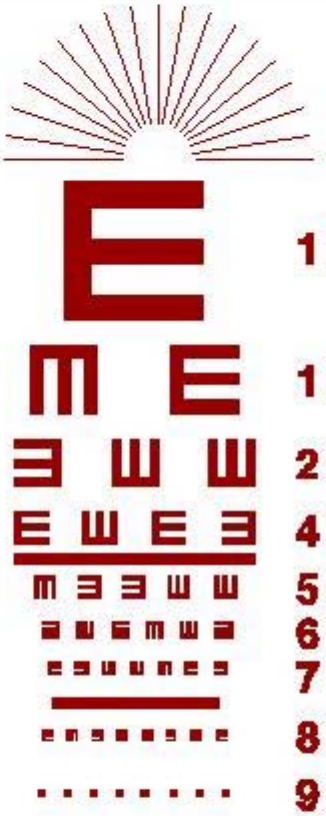
OPHTHALMOLOGY





HCFA
Health Care Financing Administration

TrailBlazer
HEALTH ENTERPRISES, LLC℠

Medicare Part B

☆ ☆ IMPORTANT ☆ ☆

The information provided in this handbook was current as of August 2001. Any changes or new information superseding the information in this book are provided in the Medicare Part B newsletters with publication dates after August 2001. Medicare Part B newsletters are available at: http://www.the-medicare.com/pubs/index.asp

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HCFA MEDICARE • MEDICAID Health Care Financing Administration

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GENERAL OPHTHALMOLOGIC SERVICES

DESCRIPTION

There are two levels of general ophthalmologic services – intermediate and comprehensive. These codes are appropriate for services to new or established patients when the level of service includes several routine optometric/ophthalmologic examination techniques, such as slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, tonometry, and motor evaluation that are integrated with and cannot be separated from the diagnostic evaluation. Itemization of individual service components is not appropriate.

The physical examination elements of an ophthalmologic examination include:

- visual acuity;
- visual fields (required for comprehensive level);
- eyelids and adnexa (required intermediate level);
- ocular mobility (required for comprehensive level);
- pupils/iris;
- cornea;
- anterior chamber;
- lens;
- intraocular pressure;
- retina (vitreous, macula, periphery, and vessels);
- optic disc; and,
- mental status.

A comprehensive examination consists of nine or more elements and always includes fundus examination with the pupils dilated.

An intermediate examination consists of eight or fewer of the specified elements.

Services that require minimal optometric/ophthalmologic examination techniques are included in the evaluation and management codes (99201 – 99799).

COVERAGE AND BILLING ISSUES

EYE EXAMS

New Patient

92002© Eye exam, new patient
92004© Eye exam, new patient

Established Patient

92012© Eye exam, established patient
92014© Eye exam & treatment

Limited Coverage

Coverage for procedure codes 92002, 92004, 92012 and 92014 will be based on the following coverage criteria: **Covered for:**		
V410-V411	V425	V430-V431
V4561	V4569	V4578
V522	V574	V5862
V5869	V595	V652
V6751	V711	01310-01320
01730	0213	03281
03681	042	05320-05322
05329	05440-05444	05571
05579	0760-0761	0769
0770-0774	0778	07798-07799
0780	0790-0794	07950-07953
07959	09150-09152	0940-0941
0943	09481-09487	0950
09840-09843	09849	0993
11502	11509	11512
11519	11592	11599
1252	1300-1305	135

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 92002, 92004, 92012 and 92014 will be based on the following coverage criteria: **Covered for:**		
1361	1710	1721
1731	1900-1909	1911-1919
1920-1923	1928-1929	1943
1983-1984	2161	2240-2249
2250-2254	2258-2259	22803
2321	2340	2370
2419	24200-24201	24210-24211
24220-24221	24230-24231	24240-24241
24280-24281	24290-24291	2449
2468-2469	25000-25003	25010-25013
25020-25023	25030-25033	25040-25043
25050-25053	25060-25063	25070-25073
25080-25083	25090-25093	2640-2649
30011	33381	340
3410	34600-34601	34610-34611
34620	34621	34680-34681
34690-34691	3510-3511	3518-3519
3572	36000-36004	36011-36014
36019-36021	36023-36024	36029-36030
36031-36034	36040-36044	36050-36055
36059-36065	36069	36081
36089	3609	36100-36107
36110-36114	36119	3612
36130-36133	36181	36189
3619	36201-36202	36210-36218
36221	36229	36230-36237
36240-36243	36250-36257	36260-36266
36270-36277	36281-36285	36289
3629	36300-36301	36303-36308
36310-36315	36320-36322	36330-36335
36340-36343	36350-36357	36361-36363
36370-36372	3638-3639	36400-36403
36405	36410-36411	36421-36424
3643	36441-36442	36451-36457
36459-36464	36470-36477	3648-3649
36500-36504	36510-36515	36520-36521
36523-36524	36531-36532	36541-36542
36543	36544	36551-36552
36559-36565	36581-36582	36589

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 92002, 92004, 92012 and 92014 will be based on the following coverage criteria: **Covered for:**		
3659	36600-36604	36609
36610-36619	36620-36623	36630-36634
36641-36646	36650-36653	3668-3669
36800-36803	36810-36816	3682
36830-36834	36840-36847	36851-36855
36859	36860-36863	36869
3688-3689	3693-3694	36960
3698-3699	37001-37007	37020-37024
37031-37035	37040	37044
37049	37050	37052
37054-37055	37059	37060-37064
3708-3709	37100-37105	37110-37116
37120-37124	37130-37132	37140-37146
37148-37149	37150-37158	37160-37162
37171-37173	37181-37182	37189
3719	37200-37205	37210-37215
37230-37231	37233	37239
37240-37245	37250-37256	37261-37264
37271-37275	37281	37289
3729	37300-37302	37311-37313
3732	37331-37334	3734-3736
3738-3739	37400-37405	37410-37414
37420-37423	37430-37432	37434
37441	37443-37446	37450-37456
37481-37487	37489	3749
37500-37503	37511-37516	37520-37522
37530-37533	37541-37543	37551-37554
37556-37557	37561	37569
37581	37589	3759
37600-37604	37610-37613	37621-37622
37630-37636	37640-37647	37650-37652
3766	37681-37682	37689
3769	37700-37704	37710-37716
37730-37734	37739	37741-37742
37749	37751-37754	37761-37763
37771-37773	37775	3779
37800-37808	37810-37818	37820-37824
37830-37835	37840-37845	37850-37856
37860-37863	37871-37873	37881-37887

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 92002, 92004, 92012 and 92014 will be based on the following coverage criteria: **Covered for:**		
3789	37900-37907	37909
37911-37916	37919	37921-37926
37929	37931-37934	37939
37940-37943	37945-37946	37950-37959
3798	37990-37993	37999
64800-64804	69461	6953
74300	74303	74306
74310-74312	74320-74322	74330-74339
74341-74349	74351-74359	74361-74366
74369	7438-7439	8700-8704
8708-8709	8710-8717	8719
9095	9180-9182	9189
9210-9213	9219	9251
9300-9302	9308-9309	9400-9405
9409	94102	94112
94122	94132	94142
94152	9500-9503	9509
9765	99651	99653
99659	99669	99670
99799	9983	99851
99859	9986	99882
99889	9989	

Routine Eye Exams

Routine services are excluded from payment under the Medicare program. This exclusion applies to eye examinations and evaluation and management services for the purpose of prescribing, fitting or changing eyeglasses or contact lenses for refractive errors. Accordingly, claims for services reported with ICD-9-CM codes 3670-3671, 3672-36722, 36731-36732, 3674, 36751-36753, 36781, 36789 and 3679 will be denied as routine eye examinations.

COVERAGE AND BILLING ISSUES

Non-Routine Services

Physician services performed in conjunction with an eye disease (e.g., glaucoma or cataracts) or for postsurgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, or for permanent prosthetic lenses required by an individual lacking the organic lenses of the eye, whether by surgical removal or congenital disease, are not considered routine services.

Coverage

The coverage of services rendered by an ophthalmologist is dependent on the purpose of the examination rather than on the ultimate diagnosis of the patient's condition.

- When a Medicare patient goes to an ophthalmologist with a complaint or symptoms of an eye disease or injury, the services (except for eye refractions) are covered regardless of the fact that only eyeglasses were prescribed.

- However, when a Medicare patient goes to an ophthalmologist for an eye examination with no specific complaint, the expenses for the examination are not covered even though as a result of such examination, the doctor discovered a pathologic condition.

Refractions

Expenses for all refractive procedures are excluded from Medicare coverage.

Waiver

Routine eye exams and refractive services are both Medicare program exclusions. Therefore, they are not subject to the waiver of liability provision. Advance notification to the beneficiary is not required.

COVERAGE AND BILLING ISSUES

OPHTHALMIC A- AND B-SCANS

Description

Ultrasound diagnostic non-invasive procedures are used to determine the composition and contours of ocular and orbital structures. A-scan technology implies a one-dimensional measurement procedure; B-scan implies a two-dimensional procedure.

HCPCS Codes

76511©	Echo exam of eye
76512©	Echo exam of eye
76513©	Echo exam of eye, waterbath
76516©	Echo exam of eye
76519©	Echo exam of eye

Indications of Coverage

A-scan technology is used:

- prior to cataract surgery to help determine the axial length of the eye to calculate the dioptric strength of the intraocular lens;
- to differentiate between various intraocular tumors;
- to measure tumor size; and,
- to differentiate other intraocular and orbital pathology.

B-scan technology is used when clouding of the ocular tissues prevents proper visualization and examination of the structure of the eye to evaluate the retina, intraocular tumors or other intraocular disorders.

A- and B-scans may be appropriately performed together to:

- diagnose tumors of the eye;

  Note: The B-scan determines the shape, location and extent of the tumor, while the A-scan demonstrates the precise size of the tumor.

- diagnose diseases of the orbit;

  Note: Upon completion of a B-scan, the A-scan is used to determine the differential diagnosis.

  and,

- diagnose intraocular disease.

  Note: Upon completion of a B-scan and when the B-scan cannot provide adequate information for definitive diagnosis, the A-scan can be used to determine a differential diagnosis.

ICD-9-CM Codes That Support Medical Necessity

Medicare is establishing the following limited coverage for code 76511: **Covered for:**	
1900-1901	Malignant neoplasm of eye
1905-1906	
1908	Malignant neoplasm of other specified sites of eye
2241	Benign neoplasm of orbit
2245-2246	
2248	Benign neoplasm of other specified parts of eye
2468	Other specified disorders of thyroid
36050	Foreign body, magnetic, intraocular, unspecified
36100	Retinal detachment with retinal defect, unspecified
36103	Recent detachment with giant tear
3612	Serous retinal detachment

COVERAGE AND BILLING ISSUES

Medicare is establishing the following limited coverage for code 76511: **Covered for:**	
36130	Retinal defect, unspecified
36181	Traction detachment of retina
36221	Retrolental fibroplasia
36242-36243	Separation of retinal layers
36362	Expulsive choroidal hemorrhage
36370	Choroidal detachment, unspecified
36405	Hypopyon
36441	Hyphema
37611-37612	Chronic inflammatory disorders of orbit
37630	Exophthalmos, unspecified
37700	Papilledema, unspecified
37721	Drusen of optic disc
37724	Pseudopapilledema
37907	Posterior scleritis
37923	Vitreous hemorrhage
37924	Other vitreous opacities

Medicare is establishing the following limited coverage for code 76512: **Covered for:**			
1900-1901	1905-1906	1908	2241
2245-2246	2248	2468	36050
36100	36103	3612	36130
36181	36221	36242-36243	36362
36370	36405	36441	36617-36618
36619	36622-36623	36632-36633	37100-37105
37611-37612	37630	37700	37721
37724	37907	37923	37924
74330	9213		

Medicare is establishing the following limited coverage for code 76519: **Covered for:**			
36600-36604	36609	36610-36611	36613-36619
36620-36623	36630-36634	36641-36646	36650-36653
3668-3669	37931	37932	74330-74337
74339			

COVERAGE AND BILLING ISSUES

Reasons for Denial

Pre- and post-operative evaluations and measurements (i.e., ophthalmic echography, codes 76511-76519, etc.) performed in conjunction with correction of refractive problems or other ineligible procedures excluded from coverage under Section 1862 (a) (7) of the Act are considered screening and therefore, denied.

Pricing

CPT Code 76519©, echo exam of eye, is priced in a different manner when done bilaterally.

- The Intraocular Lens (IOL) calculation, which is regarded as the professional component (76519-26), is performed only for the eye that requires an implant. It is uncommon for an IOL implant to be required for both eyes at the same time. However, if it is necessary to perform an implant on both eyes, report the professional component code (76519-26) and use a quantity billed of two. Full payment for the professional component may be made for each eye if the physician calculates the IOL power for both eyes on the same day.

- The technical component (76519-TC) is typically performed on both eyes on the same day. Therefore, no additional reimbursement will be made because both eyes are done. Do not report the service bilaterally or with a quantity of two.

Note: Since the technical component is not payable for both eyes, neither is the total component procedure.

Example: The following example illustrates the correct filing method for both the technical and professional components when the calculation for an IOL is done on both eyes on the same day.

Code	Quantity Billed
76519-26	2
76519-TC	1

This will result in full payment for the calculations for both eyes.

COVERAGE AND BILLING ISSUES

CORNEAL TOPOGRAPHY

CPT Code

92499© Eye service or procedure

As there is no current CPT code for corneal topography, report the unlisted procedure code 92499 for this service. As with any unlisted CPT code, a description of the service must be given.

Note: This procedure may be billed as a unilateral code except the technical component may be billed only once, even if the procedure is performed bilaterally.

The limiting charge should be calculated accordingly.

Coverage

Coverage for corneal topography will be allowed as a separate procedure when billed for one of the following indications:

- postoperative cataract extraction, penetration keratoplasty, lamellar keratoplasty, refractive keratoplasty with acquired astigmatism;
- preoperative evaluation or irregular corneal curvature for intraocular lens power determination;
- identification and follow-up for corneal disease causing irregular astigmatism – keratoconus, pterygium, peripheral corneal degenerations (Mooren's ulcer, Terrien's degeneration);
- iatrogenic corneal astigmatism-surgically induced, trauma induced, corneal distortion from contact lens wear; or,
- unexplained visual loss thought to be due to irregular corneal astigmatism.

Note: The limiting charge should be calculated accordingly.

COVERAGE AND BILLING ISSUES

Limited Coverage

Coverage for corneal topography, procedure code 92499, will based on the following limited coverage: **Covered for:**	
36720	Astigmatism, unspecified
36722	Irregular astigmatism
74341	Congenital anomalies for corneal size and shape

COVERAGE AND BILLING ISSUES

OPHTHALMOSCOPY

Extended ophthalmoscopy is a more extensive examination than a routine examination. It includes an examination of the retina with retinal drawings, interpretation and report.

CPT Codes

The following procedure codes should be used for extended ophthalmoscopy services:

92225© Special eye exam, initial
92226© Special eye exam, subsequent

Procedures considered an integral part of the ophthalmological new or established codes are:

- brightness activity test (BAT);
- case history;
- corneal sensation/examination;
- dilation of pupil;
- drops;
- exophthalmous test;
- external examination of the eye;
- Threshold Armster Grid test;
- keratometry (K reading);
- laser interferometry;
- ocular motility;
- Potential Acuity Meter (PAM) test;
- prescription of prasthetic lenses;
- retinometry;
- routine opthalmoscopy;
- schirmer test;
- Slit lamp;
- super pinhole test;
- tear film adquancy;
- transilluination of iris and globe;
- visual acuity;
- phacometry; and,
- general medical observation.

COVERAGE AND BILLING ISSUES

Medical Necessity

Based on information from the medical community and specialty society, extended ophthalmoscopy is appropriate when one of the following criteria is met:

- a serious retinal condition exists or is suspected based on a routine ophthalmoscopy that requires further detailed study such as:
    - detailed study of a pre-retinal membrane;
    - macular hole;
    - diabetic clinically significant macular edema;
    - 360 scleral depression;
    - study of a retinal tear;
    - detachment;
    - uncontrolled glaucoma (in some instances, where detailed drawings of the optic nerve and changes need to be documented);
    - suspected retinal tear with sudden onset symptomatic floaters or vitreous hemorrhage; and,
    - suspected wet age related macular degeneration or central serous retinopathy;

OR,

- another diagnostic technique (in addition to routine direct and indirect) is used and documented such as:
    - 360 scleral depression;
    - fundus contact lens; or,
    - 90D lens.

COVERAGE AND BILLING ISSUES

Limited Coverage

Coverage for procedure codes 92225 and 92226 will be based on the following limited coverage: **Denied for:**	
36600-36604	Infantile, juvenile, and presenile cataract
36609	Other and combined forms of non senile cataract
36610-36619	Senile cataract
36620-36623	Traumatic cataract
36630-36634	Cataract secondary to ocular disorders
36641-36646	Cataract associated with other disorders
36650-36653	After-cataract
3668-3669	Other and unspecified cataract
74330-74337	Congenital cataract and lens anomalies
74339	Other

Documentation

Medicare expects a detailed retinal drawing to be included in the documentation and maintained in the patient's medical records.

COVERAGE AND BILLING ISSUES

FLUORESCEIN ANGIOSCOPY AND ANGIOGRAPHY

CPT Codes

Use the following codes should be used for fluorescein angioscopy and angiography services:

92230© Eye exam with photos
92235© Eye exam with photos

Limited Coverage

Coverage for procedure codes 92230 will be based on the following limited coverage: **Denied for:**				
36600-36604	36609	36610-36619	36620-36623	36630-36634
36641-36646	36650-36653	3668-3669	74330-74337	74339

Coverage for procedure codes 92235 will be based on the following limited coverage: **Covered for:**				
V6751	11592	135	1906	2246
22809	25000-25003	25010-25013	25020-25023	25030-25033
25040-25043	25050-25053	25060-25063	25070-25073	25080-25083
25090-25093	340	3572	36021	36110-36114
36119	3612	36201-36202	36211-36212	36214-36216
36218	36230-36232	36234-36237	36241-36243	36250-36255
36256	36274-36277	36281	36283-36284	36300-36301
36303-36308	36315	36320-36322	36331	36343
36355-36356	36363	36371-36372	36641	37721
37724	37741	64800-64804	64810-64814	64820-64824
64830-64834	64840-64844	64850-64854	64860-64864	64870-64874
64890-64894				

COVERAGE AND BILLING ISSUES

FUNDUS PHOTOGRAPHY

CPT Codes

The following procedure code should be used for fundus photography procedures:

92250© Eye exam with photos

Limited Coverage

Coverage for procedure code 92250 will be based on the following: **Covered for:**				
V5869	V6751	09485	11590-11595	11599
1301	1302	1900-1909	2245	2246
2340	2388	2398	25000-25003	25010-25013
25020-25023	25030-25033	25040-25043	25050-25053	25060-25063
25070-25073	25080-25083	25090-25093	2702	340
3572	36000	36001	36002	36011
36012	36019	36021	36023	36024
36030	36050	36060	36100	36101
36102	36103	36104	36105	36106
36107	36110	3612	36130	36131
36132	36133	36181	36189	3619
36201	36202	36211	36212	36213
36214	36215	36216	36217	36218
36221	36230	36231	36232	36233
36235	36236	36237	36240	36241
36242	36243	36250	36251	36252
36253	36254	36256	36257	36260
36263	36266	36270	36273	36274
36275	36276	36281	36282	36283
36284	36300	36301	36303	36304
36305	36306	36308	36310	36311
36312	36313	36314	36315	36320
36321	36322	36330	36331	36332
36334	36335	36340	36341	36342
36343	36350	36351	36352	36353

COVERAGE AND BILLING ISSUES

Coverage for procedure code 92250 will be based on the following: **Covered for:**				
36354	36355	36356	36357	36361
36362	36363	36370	36371	36372
3638	3639	3643	36500	36501
36502	36503	36504	36510	36511
36512	36513	36514	36515	36520
36521	36522	36523	36524	36531
36532	36541	36542	36543	36544
36551	36552	36559	36560	36561
36562	36563	36564	36565	36581
36582	36589	3659	36641	37700
37701	37702	37703	37704	37710
37711	37712	37713	37714	37715
37716	37721	37722	37723	37724
37730	37731	37732	37733	37734
37739	37741	37749	3779	37907
37911	37925	37932	37934	64800-64804
64810-64814	64820-64824	64830-64834	64840-64844	64850-64854
64860-64864	64870-64874	64890-64894	74352	74355
8715	8716	9614		

COVERAGE AND BILLING ISSUES

OPHTHALMODYNAMOMETRY

CPT Code

Use the following procedure code should be used for ophthalmodynamometry services.

92260© Ophthalmoscopy/dynamometry

Limited Coverage

Coverage for procedure code 92260 will be based on the following limited coverage: **Covered for:**				
25000-25003	25010-25013	25020-25023	25030-25033	25040-25043
25050-25053	25060-25063	25070-25073	25080-25083	25090-25093
34840-34844	3572	36201-36202	36284	36641
4358	64800-64804	64810-64814	64820-64824	64830-64834
64840-64844	64850-64854	64860-64864	64870-64874	64890-64894

Note: This procedure is considered by the medical community to be obsolete except in unusual circumstances. This procedure should be billed in rare instances.

COVERAGE AND BILLING ISSUES

BANDAGE LENS

CPT Code

Procedure 92070 is an ophthalmological procedure where a disposable, soft or extended wear soft, or a hard contact lens is filled by the physician to treat a diseased or injured eye.

92070© Fitting of contact lens

Limited Coverage

Coverage for procedure code 92070 is based on the following limited coverage: **Covered for:**	
05321	Herpes zoster keratoconjunctivitis
05443	Herpes simplex disciform keratitis
3510	Bell's palsy
36032	Ocular fistula causing hypotony
36034	Flat anterior chamber
36722	Irregular astigmatism
37000	Corneal ulcer, unspecified
37006	Perforated corneal ulcer
37007	Mooren's ulcer
37020	Superficial keratitis, unspecified
37021	Punctate keratitis
37023	Filamentary keratitis
37033	Keratoconjunctivitis sicca, not specified as Sjögren's
37034	Exposure keratoconjunctivitis
37035	Neurotropic keratoconjunctivitis
37120	Corneal edema, unspecified
37123	Bullous keratopathy
37142	Recurrent erosion of cornea
37143	Band-shaped keratopathy
37152	Other anterior corneal dystrophies

COVERAGE AND BILLING ISSUES

Coverage for procedure code 92070 is based on the following limited coverage: **Covered for:**	
37157	Endothelial corneal dystrophy
37162	Keratoconus, acute hydrops
37172	Descemetocele
37400	Entropion, unspecified
37410	Ectropion, unspecified
37515	Tear film insufficiency, unspecified
7102	Sicca syndrome
8710	Ocular laceration without prolapse of intraocular tissue
9181	Superficial injury of eye and adnexa; cornea
9300	Corneal foreign body
9402	Alkaline chemical burn of cornea and conjunctival sac
9403	Acid chemical burn of cornea and conjunctival sac
V425	Organ or tissue replaced by transplant, cornea

Notes:

- Separate payment is not allowed for the bandage lens; and,
- Corneal collagen shields are excluded from this policy.

COVERAGE AND BILLING ISSUES

GONIOSCOPY

CPT Code

The following code should be used for gonioscopy services:

92020© Special eye evaluation

Limited Coverage

Coverage for procedure code 92020 will be based on the following limited coverage: **Covered for:**	
1900	Malignant neoplasm of eyeball except conjunctiva, corneal, retina, and choroid
1904	Cornea
1905	Retina
1906	Choroid
1908	Other specified parts of eye
1984	Secondary malignant neoplasm other parts of the nervous system; meninges (cerebral) (spinal)
2240	Benign neoplasm of eyeball except conjunctiva, cornea, retina, and choroid
2244	Cornea
2245	Retina
2246	Choroid
2248	Other specified parts of eye
22803	Hemangioma of retina
22809	Hemangioma of other sites
23770	Neurofibromatosis, unspecified
25050-25051	Diabetes with ophthalmic manifestations (rubeosis iridis diabetic)
25052-25053	
28260	Sickle-cell anemia, unspecified
36000	Purulent endophthalmitis, unspecified
36001	Acute endophthalmitis

COVERAGE AND BILLING ISSUES

Coverage for procedure code 92020 will be based on the following limited coverage: **Covered for:**	
36002	Panophthalmitis
36003	Chronic endophthalmitis
36004	Vitreous abscess
36011	Sympathetic uveitis
36012	Panuveitis
36013	Parasitic endophthalmitis NOS
36014	Ophthalmia nodosa
36019	Other phacoanaphylactic endophthalmitis
36030	Hypotony, unspecified
36031	Primary hypotony
36032	Ocular fistula causing hypotony
36033	Hypotony associated with other ocular disorders
36034	Flat anterior chamber
36050	Foreign body, magnetic, intraocular, unspecified
36051	Foreign body, magnetic, in anterior chamber
36052	Foreign body, magnetic, in iris or ciliary body
36053	Foreign body, magnetic, in lens
36054	Foreign body, magnetic, in posterior wall
36059	Foreign body, magnetic, in other or multiple sites
36060	Foreign body, intraocular, unspecified
36061	Foreign body in anterior chamber
36062	Foreign body in iris or ciliary body
36063	Foreign body in lens
36064	Foreign body in vitreous
36065	Foreign body in posterior wall
36069	Foreign body in other or multiple sites
36212	Exudative retinopathy (Coats syndrome)
36218	Retinal vasculitis (Eales' disease)
36231	Central retinal artery occlusion
36235	Central retinal vein occlusion
36400	Acute and subacute iridocyclitis, unspecified
36401	Primary iridocyclitis
36402	Recurrent iridocyclitis
36403	Secondary iridocyclitis, infectious
36404	Secondary iridocyclitis, non-infectious
36405	Hypopyon
36410	Chronic iridocyclitis, unspecified
36411	Chronic iridocyclitis in diseases classified elsewhere
36421	Fuchs' heterochromic cyclitis

COVERAGE AND BILLING ISSUES

Coverage for procedure code 92020 will be based on the following limited coverage: **Covered for:**	
36422	Glaucomatocyclitic crises
36423	Lens-induced iridocyclitis
36424	Vogt-Koyanagi syndrome
3643	Unspecified iridocyclitis
36441	Hyphema
36442	Rubeosis iridis
36451	Essential or progressive iris atrophy
36452	Iridoschisis
36453	Pigmentary iris degeneration
36454	Degeneration of pupillary margin
36455	Miotic cysts of pupillary margin
36456	Degenerative changes of chamber angle
36457	Degenerative changes of ciliary body
36459	Other iris atrophy
36460	Idiopathic cysts
36461	Implantation cysts
36462	Exudative cysts of iris or anterior chamber
36463	Primary cyst of pars plana
36464	Exudative cyst of pars plana
36470	Adhesions of iris, unspecified
36471	Posterior synechiae
36472	Anterior synechiae
36473	Goniosynechiae
36474	Pupillary membranes
36475	Pupillary abnormalities; deformed pupil, rupture of sphincter pupil, ectopic pupil
36476	Iridodialysis
36477	Recession of chamber angle
3648	Other disorders of iris and ciliary body
3649	Unspecified disorder of iris and ciliary body
36500-36504	Glaucoma suspect
36510-36515	Open angle glaucoma
36520-36524	Primary angle-closure glaucoma
36531-36532	Corticosteroid-induced glaucoma
36541-36544	Glaucoma associated with congenital anomalies, dystrophies and systemic syndromes
36551-36552	Glaucoma associated with disorders of the lens
36559	
36560-36565	Glaucoma associated with other ocular disorders

COVERAGE AND BILLING ISSUES

Coverage for procedure code 92020 will be based on the following limited coverage: **Covered for:**	
36581-36582	Other specified forms of glaucoma
36589	Other specified glaucoma
3659	Unspecified glaucoma
36600	Non senile cataract, unspecified
36601	Anterior subcapsular polar cataract
36602	Posterior subcapsular polar cataract
36603	Cortical, lamellar, or zonular cataract
36604	Nuclear cataract
36609	Other and combined forms of non-senile cataract
37113	Posterior corneal pigmentation
37931	Aphakia
37932	Subluxation of lens
37933	Anterior dislocation of lens
37934	Posterior dislocation of lens
37939	Other disorder of lens
74344	Specified anomalies of anterior chamber, chamber angle and related structures (Peters' and Reiger's) anomaly

COVERAGE AND BILLING ISSUES

ANTERIOR SEGMENT PHOTOGRAPHY

CPT Code

The following procedure should be used for anterior segment photography services:

92286© Internal eye photography

Limited Coverage

Coverage for procedure code 92286 will be based on the following limited coverage: **Covered for:**	
37120-37124	Corneal edema
37157-37158	Endothelial dystrophy
99653	Mechanical complication involving ocular lens prosthesis
V410-V411	Problems with eye and sight
V431	Replacement of lens of eye by prosthesis
V4561	States following surgery of the eye
V4569	Other states following surgery of eye and adnexal

COVERAGE AND BILLING ISSUES

Coding Guidelines

If V41, 43 or 45 series are used as diagnosis codes, one or more of the following conditions must be documented in the patient's medical records:

- Patient is about to undergo a secondary intraocular lens implant;
- Patient had a previous intraocular surgery and requires cataract surgery;
- Patient is about to be fitted with extended wear contact lens after intraocular surgery; or,
- Patient is about to undergo a surgical procedure associated with a higher risk to corneal endothelium, i.e., phacoemulsification or refractive surgery.

COVERAGE AND BILLING ISSUES

LACRIMAL PUNCTUM CLOSURE

CPT Code

Use the following procedure codes should be used to bill for lacrimal punctum closure:

68760© Close tear duct opening
68761© Close tear duct opening
68801© Dilate tear duct opening

Dry Eye Syndrome Defined

Dry eye syndrome is generally characterized by tearing, mucus discharge, blurred vision, itchy, red eyes, gritty sensations, burning, photophobia, or frank eye pain. Dry eye syndrome is a chronic condition and usually irreversible. It is an ocular surface disease secondary to inadequate lubrication.

Coverage

Medicare will consider reimbursement for punctum closure for moderately severe to severe dry eye syndrome.

Documentation

The physician documentation must indicate that intensive topical eye therapy and medical management have failed and/or the patient has superficial punctate keratitis, corneal thinning, ulceration or perforation or dry eye syndrome associated with certain medical diseases such as connective tissue disease.

The documentation must also support that diagnostic testing conclusively supports dry eye syndrome and that local eye therapy has been tried and found to be ineffective prior to placement of punctum plugs.

COVERAGE AND BILLING ISSUES

Testing

Dry eye symptoms are more important than tear function or volume tests;however, Schirmer's test, Rose Bengal Staining, or fluorescein staining may be helpful in diagnosis.

Temporary punctum closure by means of collagen plug implant will not be considered a diagnostic test for dry eye syndrome, but will be considered as a means in which to determine if permanent punctum closure will be effective treatment for moderately severe to severe dry eye syndrome.

Facts About Punctum Plugs

The following are facts about punctum plugs:

- Collagen punctum plugs are dissolvable and generally dissolve within seven to 10 days (these plugs are used for temporary closure of the punctum);

- Silicone punctum plugs are non-dissolvable and are considered semi-permanent as they can fall out or may need to be replaced in six months to one year (these plugs are used in semi-permanent closure of the punctum); and,

- Thermocauterization, ligation or laser surgery performed on the lacrimal punctum is considered to be used for permanent closure of the punctum.

Punctum Closures Performed in Nursing Homes

Medicare has become aware of increased performance of punctum closures in nursing home patients. The following are two requirements that must be met for Medicare to allow payment for lacrimal punctum closure procedures that are performed on nursing home residents:

- The physician's documentation must support that the referral was initiated by the patient, the patient's family, the patient's conservator or the patient's attending physician; and,

- The documentation in the patient's medical records must support that ongoing, intense medical management of the dry eye syndrome has failed.

COVERAGE AND BILLING ISSUES

Reimbursement

The following are Medicare reimbursement guidelines for punctum plugs:

- In most cases of dry eye syndrome requiring punctum plugs or punctum closure, placement of one plug in (or closure of) each lower punctum will suffice to alleviate the problem. Medicare will reimburse for two plugs per beneficiary or two permanent closures per beneficiary on any given day.

- Up to two additional plugs or two additional closure may be performed for a total of four, but documentation must clearly show that the two additional plugs or closures were medically necessary as additional treatment to alleviate the condition.

- In rare cases, up to eight punctum plugs per beneficiary might be warranted (four temporary and four permanent). Medical documentation must clearly show the medical necessity for this number of procedures being performed.

- When procedure code 68801 is performed on the same day as procedure 68760 and 68761, no separate payment will be allowed, since dilation of the punctum is considered part of placement of a plug, and is not indicated if obliteration of the punctum is done by cautery, ligation, or laser.

- Separate payment for permanent punctum plugs (code A4263) will be allowed when reported with CPT code 68761 when the services are furnished in the office setting.

- Temporary plugs (code A4262) are bundled services and are not paid separately.

COVERAGE AND BILLING ISSUES

VITRECTOMY

CPT Codes

Use the following procedure codes should be used for vitrectomy services:

67005© Partial removal of eye fluid
67010© Partial removal of eye fluid
67015© Release of eye fluid
67036© Removal of inner eye fluid
67038© Strip retinal membrane
67039© Laser treatment of retina
67040© Laser treatment of retina

Limited Coverage

Coverage for procedure codes 67005, 67010, 67036, 67038, 67039, and 67040 will be based on the following limited coverage: **Covered for:**	
25050-25053	Diabetes with ophthalmic manifestations
36000-36003	Endophthalmitis
36004	Vitreous abscess
36012	Panuveitis
36050-36055	Retained (old) intraocular foreign body, magnetic
36059	Foreign body, magnetic, in other or multiple sites
36060-36065	Retained (old) intraocular foreign body, non-magnetic
36069	Foreign body in other or multiple sites
36100-36107	Retinal detachment with retinal defect
36130	Retinal breaks without detachment
36132	Horseshoe tear of retina without detachment
36202	Proliferative diabetic retinopathy
36212	Exudative retinopathy
36252	Subretinal neovascular membranes
36254	Macular hole
36256	Macular puckering
36281	Retinal hemorrhage

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 67005, 67010, 67036, 67038, 67039, and 67040 will be based on the following limited coverage:

Covered for:

36362	Expulsive choroidal hemorrhage
36370	Choroidal detachment, unspecified
36371	Serous choroidal detachment
36372	Hemorrhagic choroidal detachment
36520	Primary angle-closure
37923	Vitreous hemorrhage
37924	Other vitreous opacities
37925	Vitreous membranes and strands
37926	Vitreous prolapse
37929	Other disorders of vitreous
37932	Subluxation of the lens (lens particles)
37934	Posterior dislocation of lens
8710-8717	Open wound of the eyeball
8719	Unspecified open wound of the eyeball
99653	Dislocation of lens implant
99882	Cataract fragments in eye following cataract surgery
V4561	Cataract extraction status
V4569	States following surgery of eye and adnexa

Coverage for procedure code 67015 will be based on the following limited coverage:

Covered for:

V4561	V4569	25050-25051	25052-25053	36000
36001	36002	36003	36004	36011
36012	36013	36014	36019	36023
36024	36050-36055	36059	36060-36065	36069
36100-36107	3612	36130	36132	36181
36189	36202	36212	36215	36216
36218	36221	36229	36235	36250
36251	36252	36253	36254	36256
36257	36273	36281	36283	36310
36320	36321	36322	36361	36362
36363	36370-36372	36410	36411	36423
36424	36520	36551	36563	36600
36601	36602	36603	36604	36609
36610	36611	36612	36613	36614
36615	36616	36617	36618	36619
36620	36621	36622	36623	36630

COVERAGE AND BILLING ISSUES

Coverage for procedure code 67015 will be based on the following limited coverage: **Covered for:**				
36631	36632	36633	36634	36641
36642	36643	36644	36645	36646
36650	36651	36652	36653	3668
3669	37921	37922	37923-37924	37925
37926	37929	37931	37932	37934
74330	74331	74332	74333	74334
74335	74336	74337	74339	8710-8717
8719	99653	99882		

COVERAGE AND BILLING ISSUES

TRABECULOPLASTY

CPT Code

The following procedure code should be used for trabeculoplasty services:

65855© Laser surgery of eye

Limited Coverage

Coverage for procedure code 65855 will be based on the following limited coverage: **Covered for:**	
V4561	Cataract extraction status
V4569	Other states following surgery of eye and adnexa
36500-36504	Glaucoma
36510-36515	
36520-36524	
36531-36532	
36541-36544	
36551-36552	
36559	
36560-36565	
36581-36582	
36589	
3659	

COVERAGE AND BILLING ISSUES

TRICHIATRIS

CPT Codes

The following procedure codes should be used for trichiasis epilation procedures:

67820© Revise eyelashes
67825© Revise eyelashes

Coverage

Procedure code 67820 is a bilateral procedure. This code should only be billed once per session, not per eye, regardless of the number of epilations performed.

Procedure code 67825 can be billed per eye, but not with a quantity greater than two. If the procedure is performed on both eyes, use the RT modifier to identify the right eye and use the LT modifier to identify the left eye.

Limited Coverage

Coverage for procedure codes 67820 and 67825 is based on the following limited coverage: **Covered for:**	
37400	Entropion, unspecified
37401	Senile entropion
37402	Mechanical entropion
37403	Spastic entropion
37404	Cicatricial entropion
37405	Trichiasis of eyelid without entropion
7042	Trichiasis

COVERAGE AND BILLING ISSUES

CPT Codes

The following procedure codes should be used for trichiasis incision procedures:

67830© Revise eyelashes
67835© Revise eyelashes

Limited Coverage

Coverage for procedure codes 67830 and 67835 will be based on the following limited coverage: **Covered for:**	
37405	Trichiasis
7042	Abnormalities of hair

COVERAGE AND BILLING ISSUES

CORNEAL TISSUE REIMBURSEMENT

HCPCS Code

Ambulatory Surgical Centers (ASCs) are able to bill Medicare for corneal tissue. The claim must have an invoice from the eye bank that has supplied the corneal tissue. Use code V2785 to bill for corneal tissue.

V2785 Processing, preserving and transporting of corneal tissue

Allowance

Medicare will consider the eye bank's invoice for the expenses that it or the organ procurement organization incurs when harvesting, processing and preserving the tissue. The eye bank's invoice must have a breakdown of all charges that were incurred to acquire the tissue. Each breakdown should define exactly the individual services that are included in it, as well as the individual costs for those services.

For clarification purposes, the harvesting of the tissue is often referred to as acquisition or procurement. The processing of the tissue is often referred to as evaluation. The preserving of the tissue is often referred to as preservation and/or storage.

The following will not be considered for payment:

- transportation;
- shipping;
- handling;
- routine testing of the tissue (e.g., HIV, hepatitis);
- educational packet;
- administrative costs;
- outpatient hospital supplies;
- patient support; and,
- community awareness education.

COVERAGE AND BILLING ISSUES

VISUAL FIELD EXAMINATION

CPT Codes

Use the following codes for visual field examinations:

92081© Visual field examination(s)
92082© Visual field examination(s)
92083© Visual field examination(s)

Reimbursement

Medicare will consider reimbursement for a visual field examination for the evaluation and/or treatment of abnormal ophthalmologic or neurologic signs and/or symptoms, and/or known ophthalmologic disease or injuries. However, the physician's documentation in the medical record must reflect the specific medical necessity for the performance of a visual field examination. Documentation must be made available to Medicare upon request.

COVERAGE AND BILLING ISSUES

Limited Coverage

Coverage for procedure codes 92081, 92082 and 92083 will be based on the following: **Covered for:**	
1900	Malignant neoplasm of eyeball, except conjunctiva, cornea, retina, and choroid
1901	Malignant neoplasm of orbit
1902	Malignant neoplasm of lacrimal gland
1903	Malignant neoplasm of conjunctiva
1904	Malignant neoplasm of cornea
1905	Malignant neoplasm of retina
1906	Malignant neoplasm of choroid
1907	Malignant neoplasm of lacrimal duct
1908	Malignant neoplasm of other specified sites of eye
1909	Malignant neoplasm of eye, part unspecified
1920	Malignant neoplasm of cranial nerves
2251	Benign neoplasm of cranial nerves
2396	Neoplasm of unspecified nature of brain
24200	Toxic diffuse goiter without mention of thyrotoxic crisis or storm
24201	Toxic diffuse goiter with mention of thyrotoxic crisis or storm
2598	Other specific endocrine disorders
2645	Vitamin A deficiency with night blindness
30011	Conversion disorder
3482	Benign intracranial hypertension
36023	Siderosis of globe
36029	Other digestive disorders of globe
36100	Retinal detachment with retinal defect, unspecified
36101	Recent retinal detachment, partial, with single defect
36102	Recent retinal detachment, partial, with multiple defects
36103	Recent retinal detachment, partial, with giant tear
36104	Recent retinal detachment, partial, with retinal dialysis
36105	Recent retinal detachment, total or subtotal
36106	Old retinal detachment, partial
36107	Old retinal detachment, total or subtotal
36110	Retinoschisis, unspecified
36111	Flat retinoschisis
36112	Bullous retinoschisis
36113	Primary retinal cysts

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 92081, 92082 and 92083 will be based on the following: **Covered for:**	
36114	Secondary retinal cysts
36119	Other retinoschisis and retinal cysts
3612	Serous retinal detachment
36130	Retinal defect, unspecified
36131	Round hole of retina without detachment
36132	Horseshoe tear of retina without detachment
36133	Multiple defects of retina without detachment
36181	Traction detachment of retina
36189	Other forms of retinal detachment
3619	Unspecified retinal detachment
36201	Background diabetic retinopathy
36202	Proliferative diabetic retinopathy
36210	Background retinopathy, unspecified
36211	Hypertensive retinopathy
36212	Exudative retinopathy
36213	Changes in vascular appearance of retina
36214	Retinal microaneurysms NOS
36215	Retinal telangiectasia
36216	Retinal neovascularization NOS
36217	Other intraretinal microvascular abnormalities
36218	Retinal vasculitis
36221	Retrolental fibroplasia
36229	Other non-diabetic proliferative retinopathy
36230	Retinal vascular occlusion, unspecified
36231	Central retinal artery occlusion
36232	Retinal arterial branch occlusion
36233	Partial retinal arterial occlusion
36234	Transient retinal arterial occlusion
36235	Central retinal vein occlusion
36236	Venous tributary (branch) occlusion of retina
36237	Venous engorgement of retina
36240	Retinal layer separation, unspecified
36241	Central serous retinopathy
36242	Serous detachment of retinal pigment epithelium
36243	Hemorrhagic detachment of retinal pigment epithelium
36250	Macular degeneration (senile) of retina, unspecified
36251	Non-exudative senile macular degeneration of retina
36252	Exudative senile macular degeneration of retina

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 92081, 92082 and 92083 will be based on the following: **Covered for:**	
36253	Cystoid macular degeneration of retina
36254	Macular cyst, hole, or pseudohole of retina
36255	Toxic maculopathy of retina
36256	Macular puckering of retina
36257	Drusen (degenerative) of retina
36260	Peripheral retinal degeneration, unspecified
36261	Paving stone degeneration of retina
36262	Microcystoid degeneration of retina
36263	Lattice degeneration of retina
36264	Senile reticular degeneration of retina
36265	Secondary pigmentary degeneration of retina
36266	Secondary vitreoretinal degenerations
36270	Hereditary retinal dystrophy, unspecified
36271	Retinal dystrophy in systemic or cerebroretinal lipidoses
36272	Retinal dystrophy in other systemic disorders and syndromes
36273	Vitreoretinal dystrophies
36274	Pigmentary retinal dystrophy
36275	Other dystrophies primarily involving the sensory retina
36276	Dystrophies primarily involving the retinal pigment epithelium
36277	Retinal dystrophies primarily involving Bruch's membrane
36281	Retinal hemorrhage
36282	Retinal exudates and deposits
36283	Retinal edema
36284	Retinal ischemia
36285	Retinal nerve fiber bundle defects
36289	Other retinal disorders
3629	Unspecified retinal disorder
36300	Focal chorioretinitis, unspecified
36301	Focal choroiditis and chorioretinitis, juxtapapillary
36303	Focal choroiditis and chorioretinitis of other posterior pole
36304	Focal choroiditis and chorioretinitis, peripheral
36305	Focal retinitis and retinochoroiditis, juxtapapillary

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 92081, 92082 and 92083 will be based on the following: **Covered for:**	
36306	Focal retinitis and retinochoroiditis, macular or paramacular
36307	Focal retinitis and retinochoroiditis of other posterior pole
36308	Focal retinitis and retinochoroiditis, peripheral
36310	Disseminated chorioretinitis, unspecified
36311	Disseminated choroiditis and chorioretinitis, posterior pole
36312	Disseminated choroiditis and chorioretinitis, peripheral
36313	Disseminated choroiditis and chorioretinitis, generalized
36314	Disseminated retinitis and retinochoroiditis, metastatic
36315	Disseminated retinitis and retinochoroiditis, pigment epitheliopathy
36320	Chorioretinitis, unspecified
36321	Pars planitis
36322	Harada's disease
36330	Chorioretinal scar, unspecified
36331	Solar retinopathy
36332	Other macular scars of retina
36333	Other scars of posterior pole of retina
36334	Peripheral scars of retina
36335	Disseminated scars of retina
36340	Choroidal degeneration, unspecified
36341	Senile atrophy of choroid
36342	Diffuse secondary atrophy of choroid
36343	Angioid streaks of choroid
36350	Hereditary choroidal dystrophy or atrophy, unspecified
36351	Circumpapillary dystrophy of choroid, partial
36352	Circumpapillary dystrophy of choroid, total
36353	Central dystrophy of choroid, partial
36354	Central choroidal atrophy, total
36355	Choroideremia
36356	Other diffuse or generalized dystrophy of choroid, partial
36357	Other diffuse or generalized dystrophy of choroid, total

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 92081, 92082 and 92083 will be based on the following: **Covered for:**	
36361	Choroidal hemorrhage, unspecified
36362	Expulsive choroidal hemorrhage
36363	Choroidal rupture
36370	Choroidal detachment, unspecified
36371	Serous choroidal detachment
36372	Hemorrhagic choroidal detachment
3638	Other disorders of choroid
3639	Unspecified disorder of choroid
36500	Preglaucoma, unspecified
36501	Open angle with borderline glaucoma findings
36502	Anatomical narrow angle borderline glaucoma
36503	Steroid responders borderline glaucoma
36504	Ocular hypertension
36510	Open-angle glaucoma, unspecified
36511	Primary open angle glaucoma
36512	Low tension glaucoma
36513	Pigmentary glaucoma
36514	Glaucoma of childhood
36515	Residual stage of open angle glaucoma
36520	Primary angle-closure glaucoma, unspecified
36521	Intermittent angle-closure glaucoma
36522	Acute angle-closure glaucoma
36523	Chronic angle-closure glaucoma
36524	Residual stage of angle-closure glaucoma
36531	Corticosteroid-induced glaucoma, glaucomatous stage
36532	Corticosteroid-induced glaucoma, residual stage
36541	Glaucoma associated with chamber angle anomalies
36542	Glaucoma associated with anomalies of iris
36543	Glaucoma associated with other anterior segment anomalies
36544	Glaucoma associated with systemic syndromes
36551	Phacolytic glaucoma
36552	Pseudoexfoliation glaucoma
36559	Glaucoma associated with other lens disorders
36560	Glaucoma associated with unspecified ocular disorder
36561	Glaucoma associated with pupillary block
36562	Glaucoma associated with ocular inflammations

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 92081, 92082 and 92083 will be based on the following: **Covered for:**	
36563	Glaucoma associated with vascular disorders
36564	Glaucoma associated with tumors or cysts
36565	Glaucoma associated with ocular trauma
36581	Hypersecretion glaucoma
36582	Glaucoma with increased episcleral venous pressure
36589	Other specified glaucoma
3659	Unspecified glaucoma
36800	Amblyopia, unspecified
36801	Strabismic amblyopia
36802	Deprivation amblyopia
36803	Refractive amblyopia
36810	Subjective visual disturbance, unspecified
36811	Sudden visual loss
36812	Transient visual loss
36813	Visual discomfort
36814	Visual distortions of shape and size
36815	Other visual distortions and entoptic phenomena
36816	Psychophysical visual disturbances
3682	Diplopia
36830	Binocular vision disorder, unspecified
36831	Suppression of binocular vision
36832	Simultaneous visual perception without fusion
36833	Fusion with defective stereopsis
36834	Abnormal retinal correspondence
36840	Visual field defect, unspecified
36841	Scotoma involving central area
36842	Scotoma of blind spot area
36843	Sector or arcuate visual field defect
36844	Other localized visual field defect
36845	Generalized visual field contraction or constriction
36846	Homonymous bilateral field defects
36847	Heteronymous bilateral field defects
36851	Protan defect
36852	Deutan defect
36853	Tritan defect
36854	Achromatopsia
36855	Acquired color vision deficiencies
36859	Other color vision deficiencies
36860	Night blindness, unspecified

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 92081, 92082 and 92083 will be based on the following: **Covered for:**	
36861	Congenital night blindness
36862	Acquired night blindness
36863	Abnormal dark adaptation curve
36869	Other night blindness
3688	Other specified visual disturbances
3689	Unspecified visual disturbance
36900	Blindness of both eyes, impairment level not further specified
36901	Better eye: total vision impairment; lesser eye: total vision impairment
36902	Better eye: near-total vision impairment; lesser eye: not further specified
36903	Better eye: near-total vision impairment; lesser eye: total vision impairment
36904	Better eye: near-total vision impairment; lesser eye: near-total vision impairment
36905	Better eye: profound vision impairment; lesser eye: not further specified
36906	Better eye: profound vision impairment; lesser eye: total vision impairment
36907	Better eye: profound vision impairment; lesser eye: near-total vision impairment
36908	Better eye: profound vision impairment; lesser eye: profound vision impairment
36910	Blindness, one eye; low vision other eye
36911	Better eye: severe vision impairment; lesser eye: blind, not further specified
36912	Better eye: severe vision impairment; lesser eye: total vision impairment
36913	Better eye: severe vision impairment; lesser eye: near-total vision impairment
36914	Better eye: severe vision impairment; lesser eye: profound vision impairment
36915	Better eye: moderate vision impairment; lesser eye: blind, not further specified
36916	Better eye: moderate vision impairment; lesser eye: total vision impairment
36917	Better eye: moderate vision impairment; lesser eye: near-total vision impairment

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 92081, 92082 and 92083 will be based on the following: **Covered for:**	
36918	Better eye: moderate vision impairment; lesser eye: profound vision impairment
36920	Low vision, both eyes, not otherwise specified
36921	Better eye: severe vision impairment; lesser eye; impairment not further specified
36922	Better eye: severe vision impairment; lesser eye: severe vision impairment
36923	Better eye: moderate vision impairment; lesser eye: impairment not further specified
36924	Better eye: moderate vision impairment; lesser eye: severe vision impairment
36925	Better eye: moderate vision impairment; lesser eye: moderate vision impairment
3693	Unqualified visual loss, both eyes
3694	Legal blindness, as defined in U.S.A.
36960	Blindness, one eye, not otherwise specified
36961	One eye: total vision impairment; other eye: not specified
36962	One eye: total vision impairment; other eye: near-normal vision
36963	One eye: total vision impairment; other eye: normal vision
36964	One eye: near-total vision impairment; other eye: vision not specified
36965	One eye: near-total vision impairment; other eye: near-normal vision
36966	One eye: near-total vision impairment; other eye: normal vision
36967	One eye: profound vision impairment; other eye: vision not specified
36968	One eye: profound vision impairment; other eye: near-normal vision
36969	One eye: profound vision impairment; other eye: normal vision
36970	Low vision, one eye, not otherwise specified
36971	One eye: severe vision impairment; other eye: vision not specified
36972	One eye: severe vision impairment; other eye: near-normal vision

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 92081, 92082 and 92083 will be based on the following: **Covered for:**	
36973	One eye: severe vision impairment; other eye: normal vision
36974	One eye: moderate vision impairment; other eye: vision not specified
36975	One eye: moderate vision impairment; other eye: near-normal vision
36976	One eye: moderate vision impairment; other eye: normal vision
3698	Unqualified visual loss, one eye
3699	Unspecified visual loss
37430	Ptosis of eyelid, unspecified
37431	Paralytic ptosis
37432	Myogenic ptosis
37433	Mechanical ptosis
37434	Blepharochalasis
37487	Dermatochalasis
37600	Acute inflammation of orbit, unspecified
37601	Orbital cellulitis
37602	Orbital periostitis
37603	Orbital osteomyelitis
37604	Orbital tenonitis
37610	Chronic inflammation of orbit, unspecified
37611	Orbital granuloma
37612	Orbital myositis
37613	Parasitic infestation of orbit
37621	Thyrotoxic exophthalmos
37622	Exophthalmic ophthalmoplegia
37630	Exophthalmos, unspecified
37631	Constant exophthalmos
37632	Orbital hemorrhage
37633	Orbital edema or congestion
37634	Intermittent exophthalmos
37635	Pulsating exophthalmos
37636	Lateral displacement of globe
37640	Deformity of orbit, unspecified
37641	Hypertelorism of orbit
37642	Exostosis of orbit
37643	Local deformities of orbit due to bone disease

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 92081, 92082 and 92083 will be based on the following: **Covered for:**	
37644	Orbital deformities associated with craniofacial deformities
37645	Atrophy of orbit
37646	Enlargement of orbit
37647	Deformity of orbit due to trauma or surgery
37650	Enophthalmos, unspecified as to cause
37651	Enophthalmos due to atrophy of orbital tissue
37652	Enophthalmos due to trauma or surgery
3766	Retained (old) foreign body following penetrating wound of orbit
37681	Orbital cysts
37682	Myopathy of extraocular muscles
37689	Other orbital disorders
3769	Unspecified disorder of orbit
37700	Papilledema, unspecified
37701	Papilledema associated with increased intracranial pressure
37702	Papilledema associated with decreased ocular pressure
37703	Papilledema associated with retinal disorder
37704	Foster-Kennedy syndrome
37710	Optic atrophy, unspecified
37711	Primary optic atrophy
37712	Post-inflammatory optic atrophy
37713	Optic atrophy associated with retinal dystrophies
37714	Glaucomatous atrophy (cupping) of optic disc
37715	Partial optic atrophy
37716	Hereditary optic atrophy
37721	Drusen of optic disc
37722	Crater-like holes of optic disc
37723	Coloboma of optic disc
37724	Pseudo papilledema
37730	Optic neuritis, unspecified
37731	Optic papillitis
37732	Retrobulbar neuritis (acute)
37733	Nutritional optic neuropathy
37734	Toxic optic neuropathy
37739	Other optic neuritis
37741	Ischemic optic neuropathy

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 92081, 92082 and 92083 will be based on the following: **Covered for:**	
37742	Hemorrhage in optic nerve sheaths
37749	Other disorders of optic nerve
37751	Disorders of optic chiasm associated with pituitary neoplasms and disorders
37752	Disorders of optic chiasm associated with other neoplasms
37753	Disorders of optic chiasm associated with vascular disorders
37754	Disorders of optic chiasm associated with inflammatory disorders
37761	Disorders of other visual pathways associated with neoplasms
37762	Disorders of other visual pathways associated with vascular disorders
37763	Disorders of other visual pathways associated with inflammatory disorders
37771	Disorders of visual cortex associated with neoplasms
37772	Disorders of visual cortex associated with vascular disorders
37773	Disorders of visual cortex associated with inflammatory disorders
37775	Cortical blindness
3779	Unspecified disorder of optic nerve and visual pathways
4465	Giant cell arteritis
74320	Buphthalmos, unspecified
74321	Simple buphthalmos
74322	Buphthalmos associated with other ocular anomalies
74344	Specified congenital anomalies of anterior chamber, chamber angle, and related structures
74345	Aniridia
74351	Vitreous anomalies, congenital
74352	Fundus coloboma
74353	Chorioretinal degeneration, congenital
74354	Congenital folds and cysts of posterior segment
74355	Congenital macular changes
74356	Other retinal changes, congenital
74357	Specified congenital anomalies of optic disc
74358	Vascular anomalies, congenital

COVERAGE AND BILLING ISSUES

Coverage for procedure codes 92081, 92082 and 92083 will be based on the following: **Covered for:**	
74359	Other congenital anomalies of posterior segment
74361	Congenital ptosis of eyelid
9500	Optic nerve injury
9501	Injury to optic chiasm
9502	Injury to optic pathways
9503	Injury to visual cortex
9509	Injury to unspecified optic nerve and pathways
V5862	Long-term (current) use of antibiotics
V5869	Long-term (current) use of other medications
V652	Person feigning illness
V6751	Follow-up examination following treatment with high-risk medication, not elsewhere classified

Waiver

If the physician is performing a visual field examination for other than the previous listed diagnoses, a written advance notification must be given to the patient before the physician may bill the patient.

As a reminder, Medicare does not pay for routine screening examinations. If a visual field is performed for screening purposes only, a written advance notification to the patient is not required. Use the appropriate screening diagnosis codes.

COVERAGE AND BILLING ISSUES

Visual Field Examination for Glaucoma

A visual field examination is generally performed most frequently for the evaluation of glaucoma and the patient's response to treatment. Based on input from the Carrier Advisory Committee, the following frequency policy for visual field examination for glaucoma has been recommended. Frequency is based on the severity of the disease process, as follows:

- Glaucoma suspect or mild damage with good control - visual field once every 12 to 18 months
- Glaucoma with moderate/advanced damage, good control - once every 12 months
- Glaucoma moderate/advanced or mild damage, borderline control - two times every 12 months
- Uncontrolled glaucoma - no more than four times per 12 months

Definitions

The following definitions are used to describe the severity of the disease (glaucoma) process:

DEFINITIONS	
A: "Target Pressure"	That Intraocular Pressure (IOP) at which the patient's glaucomatous decline in visual function is initially judged, and subsequently observed, to slow to the point at which the patient's visual needs are met for the expected remainder of his/her life. Observation of significant glaucomatous progression may require downward revision of the target pressure.

COVERAGE AND BILLING ISSUES

DEFINITIONS	
B: "Uncontrolled"	1. All acute glaucoma (e.g., Acute (ACG) inflammatory glaucoma, neovascular glaucoma, phacolytic glaucoma, etc.) are by definition uncontrolled. 2. Evidence of glaucoma progression indicates an uncontrolled state: a. Disc hemorrhage b. Progressive enlargement of optic nerve cup c. Progressive observable loss of retinal nerve fiber layer d. Reliable, reproducible, significant progression of visual field defects e. Symptomatic decline of vision, consistent with glaucoma progression, otherwise unexplainable, in patient with moderate-to-advanced glaucoma 3. IOP significantly above target pressure, judged capable of causing significant progressive glaucomatous damage, indicates an uncontrolled state.
C: "Good Control"	Achievement of an IOP at or below the target pressure without significant adverse effects. Subsequent observation confirms appropriateness of target pressure level, by documenting lack of significant glaucoma progression.
D: "Borderline Control"	Achievement of an IOP near but higher than the target pressure. Judged possibly capable of inducing further significant glaucomatous damage. Typically further IOP reduction requires surgical intervention or additional marginally tolerated medications. Careful observation of disc and visual fields is required.

COVERAGE AND BILLING ISSUES

DEFINITIONS		
E: "Mild Damage" **Examples:**	<u>Visual Field</u> a. no detectable VF defect b. "mild" generalized reduction in retinal sensitivity c. "mild" constriction of isopters d. nasal step peripheral to 20° e. small relative defects of the Bjerrum area, peripheral to 9°	<u>Optic Nerve</u> a. symmetric or vertically elongated cup enlargement: neural rim intact, rim: disc ratio > 0.2 b. focal notch; rim/disc ratio > 0.2 c. no definite pathologic cupping; previously observed disc hemorrhage
F: "Moderate Damage" **Examples:**	<u>Visual Field</u> a. "moderate" generalized reduction in retinal sensitivity b. "moderate" constriction of isopters absolute defects to within 9° of fixation c. temporal wedge	<u>Optic Nerve</u> a. enlarged optic nerve cup with neural rim remaining but sloped or pale b. focal notches with rim/disc ratio > 0.1 but < 0.2 c. prominent lamina cribrosa

COVERAGE AND BILLING ISSUES

DEFINITIONS		
G: "Advanced Damage" **Examples:**	<u>Visual Field</u> a. "severe" generalized reduction in retinal sensitivity b. "severe" constriction of isopters (i.e., 14e < 10°) c. absolute defects to within 3° of fixation d. loss of central acuity; temporal island remains	<u>Optic Nerve</u> a. Diffuse enlargement of optic nerve cup; rim/disc ratio < 0.1 b. Wipe out of all or a portion of the neuroretinal rim

COVERAGE AND BILLING ISSUES

BLEPHAROPLASTY

Definition

Surgery of the upper and lower eyelids and eyebrows is designed to provide functional visual field benefits and enhance the aesthetic appearance.

The following are terms used to describe conditions which may require blepharoplasty:

- dermatochalasis;
- blepharochalasis;
- blepharoptosis;
- pseudoptosis; and,
- ptosis.

CPT Codes

Use the following procedure codes for blepharoplasty services:

00103©	Anesth, blepharoplasty
15822©	Revision of upper eyelid
15823©	Revision of upper eyelid
67900©	Repair brow defect
67901©	Repair eyelid defect
67902©	Repair eyelid defect
67903©	Repair eyelid defect
67904©	Repair eyelid defect
67906©	Repair eyelid defect
67908©	Repair eyelid defect
67916©	Repair eyelid defect
67917©	Repair eyelid defect
67923©	Repair eyelid defect
67924©	Repair eyelid defect

COVERAGE AND BILLING ISSUES

Limited Coverage

Payment for procedure codes **15822, 15823, 67900-67904, 67906, 67908, 67916-67917 and 67923-67924** will be based on the following limited coverage criteria in addition to documentation and coverage criteria: **Covered for:**	
3734-3736	Infective dermatitis of eyelid of types resulting in deformity
37400-37405	Entropion and trichiasis of eyelid
37410-37414	Other disorders of the eyelid
37430-37434	Ptosis of eyelid
37451	Xanthelasma
37487	Dermatochalasis
37515	Tear film insufficiency, unspecified
74361	Congenital ptosis
74362	Congenital deformities of eyelids
V522	Artificial eye

COVERAGE AND BILLING ISSUES

Reimbursement

Reimbursement will be considered for blepharoplasty and repair of blepharoptosis only when these procedures are performed as functional/reconstructive surgery such as for patients with documented ptosis, pseudoptosis or dermatochalasis who require corrective surgery due to:

- interference with vision or visual field;
- difficulty reading due to upper eyelid drooping;
- looking through the eyelashes or seeing the upper eyelid skin;
- chronic blepharitis;
- visual impairment with near or far vision due to dermatochalasis, blepharochalasis or blepharoptosis;
- there is **symptomatic** redundant skin weighing down on upper lashes;
- there is **chronic, symptomatic** dermatitis of pretarsal skin caused by redundant upper lid skin; or,
- there are prosthesis difficulties in an anophthalmic socket.

Note: Payment for cosmetic surgery is excluded from the Medicare program.

Documentation Requirements

Documentation in the patient's medical record must include:

- history and physical;
- operative report;
- visual fields; and
- photographs/video.

Note: The documentation is not required to be submitted with the claim(s). However, it must be made available to Medicare upon request.

COVERAGE AND BILLING ISSUES

PHOTOGRAPHS AND VISUAL TESTING

Requirements

The following should be supported through photographs and visual field testing:

- visual fields recorded to demonstrate an absolute superior defect to within 15 degrees of fixation;
- The upper eyelid position contributes to difficulty tolerating a prosthesis in an anophthalmic socket;
- essential blepharospasm or hemifacial spasm; and,
- significant ptosis in the downgaze reading position.

Billing for Photographs

When photographs are performed, report the procedure with using the following code:

92265© Eye muscle evaluation
92270© Electro-oculography
92275© Electroretinography
92283© Color vision examination

Payment for procedure codes **92265, 92270, 92275,** and **92283** will be based on the following limited coverage criteria:

Denied for:

36600-36604	36609	36610-36619	36620-36623	36630-36634
36641-36646	36650-36653	3668-3669	74330-74337	74339

COVERAGE AND BILLING ISSUES

92285© Eye photography

Note: Code 92285 may be reported only once even though multiple views may be taken.

Payment for procedure code **92285** will be based on the following limited coverage criteria: **Denied for:**				
36600-36604	36609	36610	36619	36620-36623
36630-36634	36641-36646	36650-36653	3668-3669	74330-74337
74339				

COVERAGE AND BILLING ISSUES

CORNEAL RELAXING INCISION FOR SURGICALLY INDUCED ASTIGMATISM

CPT Codes

Use the following codes should be used for corneal relaxing incision for surgically induced astigmatism services:

65772© Correction of astigmatism
65775© Correction of astigmatism

Limited Coverage

Coverage for procedure code **65772** and **65775** will be based on the following limited coverage criteria: **Covered for:**	
36720	Atigmatism, unspecified
36721	Regular astigmatism
36722	Irregular astigmatism
99651	Corneal graft malfunction
V425	Corneal transplant status
V4561	Cataract extraction status
V4569	Post surgical state, eye and adnexa

COVERAGE AND BILLING ISSUES

YAG LASER

CPT Code

Use the following code should be used for YAG laser services:

66821© After cataract laser surgery

Coverage

YAG capsulotomy may be medically necessary for the following;

- treatment and/or diagnosis of posterior eye disease obscured by posterior capsule opacification; and/or,
- visual loss due to:
  - decreased light transmission (visual acuity <20/30) after other causes of loss of acuity have been ruled out; and/or,
  - increased glare. Test results must show decrease in two lines of visual acuity in glare tester (medium setting on the Brightness Acuity Tester (BAT) or equivalent).

Medicare payment for procedure code 66821 may be considered after cataract surgery when the retained posterior capsule opacifies to the point that the patient complains of blurred vision.

Limited Coverage

Covered for:

36650 After-cataract, unspecified
36652 Other after-cataract, not obscuring vision
36653 After-cataract, obscuring vision

COVERAGE AND BILLING ISSUES

Expectations

Medicare would not expect the physician to bill more frequently than the following percentages during the post-operative period:

0 - 90 days post-op - 5 percent

91 - 120 days post-op - 15 percent

The long-range incidence of posterior capsular clouding varies between 40-80 percent depending on the severity. Based on information from the physician community, Medicare would consider more than 20 percent of a physician's patients needing a capsulotomy during the first 120 days post-operatively from cataract surgery to be excessive and documentation would need to be reviewed for each patient to support the service being performed.

Documentation

The indications for this surgery being performed within three months post-cataract surgery must be clearly documented in the medical record (i.e., preoperative uveitis, chronic glaucoma, diabetes mellitus, prolonged use of Pilocarpine, etc.).

REMOVAL OF SECONDARY MEMBRANOUS CATARACT

CPT Code

Use the following code for removal of secondary membranous cataract services:

66830© Removal of lens lesion

Expectations

Medicare payment for procedure code 66830 may be considered; however, Medicare would not expect this code to be billed frequently. Based on information from the physician community, procedure code 66830 would rarely be performed and, therefore, rarely billed to Medicare.

COVERAGE AND BILLING ISSUES

ASSISTANT-AT-SURGERY

PRO Approval Required

Physicians are required by law to obtain prior PRO approval for assistant surgery for CPT codes 66852, 66920, 66940 and 66930.